Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: June 12, 2023

Inspection Number: 2023-1474-0005

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village at St. Clair, Windsor

Lead Inspector	**Inspector Digital Signature**
Debra Churcher (670)	Debra Churcher Digitally signed by Debra Churcher Date: 2023.06.21 07:29:47 -04'00'

Additional Inspector(s)
Terri Daly (115)
Cassandra Taylor (725)
Jennifer Bertolin (740915)
Andrea Dickinson (740895)
Adriana Congi (000751)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15, 16, 18, 23, 24, 25, 26, 29, 30, 2023.

The following intake(s) were inspected:

- Intake: #00019942- 3046-000006-23- related to alleged improper care.
- Intake: #00020310- related to alleged improper care.
- Intake: #00021165- related to alleged neglect.
- Intake: #00022991- 3046-000019-23- related to alleged improper care.
- Intake: #00083953 - Follow-up CO #002 from inspection #2023-1474-0004 -related to pain management.
- Intake: #00083954 - Follow-up CO #003 from Inspection #2023-1474-0004 - related to nutritional plan of care.
- Intake: #00083955 - Follow-up CO#004 - from Inspection 2023-1474-0004 - related to resident records.
- Intake: #00083956 - Follow-up CO #005 from Inspection 2023-1474-0004 - related to duty to

protect.

- Intake: #00083957 - Follow-up CO #006 from inspection 2023-1474-0004- related to maintenance services.
- Intake: #00083978 - Email complaint- related to alleged neglect.
- Intake: #00084213- related to IPAC concerns.
- Intake: #00084964- related to alleged improper care.
- Intake: #00085106- related to IPAC concerns.
- Intake: #00085986-3046-000033-23- related to a medication incident.
- Intake: #00086131- 3046-000034-23- related to a fall with injury.
- Intake: #00086335- related to alleged abuse.
- Intake: #00086485- 3046-000038-23- related to an injury of unknown origin.
- Intake: #00087037- 3046-000042-23- related to an injury of unknown origin.
- Intake: #00087486- 3046-000045-23- related to alleged neglect.
- Intake: #00087522- 3046-000046-23- related to an injury of unknown origin.
- Intake: #00087874-3046-000049-23- related to an injury of unknown origin.

These intakes, #00021540 - 3046-000014-23 and #00086815 - 3046-000039-23, were reviewed on May 15, 2023, with other intakes related to Falls Prevention and Management. The program issue was inspected May 15, 16, 18, 23, 24, 25, 26, 29, 30, 2023, under Inspection # 2023-1474-0005, Intake #
00086131 - 3046-000034-23, with the following areas of non-compliance identified: WN issued to O.Reg. 246/22 s. 261(1)(1) related to falls prevention education.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order ##002 from Inspection #2023-1474-0004 related to O. Reg. 246/22, s. 57 (2) inspected by Cassandra Taylor (725)

Order #003 from Inspection #2023-1474-0004 related to O. Reg. 246/22, s. 29 (3) 13. inspected by Cassandra Taylor (725)

Order #004 from Inspection #2023-1474-0004 related to O. Reg. 246/22, s. 274 (b) inspected by Cassandra Taylor (725)

Order #005 from Inspection #2023-1474-0004 related to FLTCA, 2021, s. 24 (1) inspected by Cassandra Taylor (725)

Order #006 from Inspection #2023-1474-0004 related to O. Reg. 246/22, s. 96 (2) (a) inspected by Debra Churcher (670)

The following **Inspection Protocols** were used during this inspection:

Medication Management
Safe and Secure Home
Palliative Care
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that there was a written plan of care for a resident that set out clear directions to staff relating to a caregiver preference.

Rationale and Summary:

A resident was identified as requesting a specific caregiver type. Review of the resident's care plan showed that the resident required the preferred care giver type for bathing.

During an interview, General Manager (GM) confirmed that the resident had the preferred care giver type in their admission care plan for toileting, bathing, dressing and hygiene and that the resident's most recent care plan only indicated that the resident required the preferred care giver type for bathing. When asked why the most recent care plan only included the preferred care giver type for bathing only, the Resident Assessment Instrument (RAI) Coordinator stated that during a care plan conversion, the information for preferred care giver type was not added.

GM stated that the resident's written plan of care was not clear relating to the resident's preference of care giver type and the expectation would have been that the care plan provided clear direction to staff.

Sources:
A resident's care plan and clinical records; interview with the GM and RAI Coordinator.

[740895]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and on the needs and preferences of that resident.

Rationale and Summary:
A resident's progress notes had indicated a request for the resident to receive an intervention after meals.

During an interview with a Personal Support Worker (PSW), they stated that the resident was only receiving the intervention after lunch.

The resident's care plan indicated the resident was to receive the intervention after lunch only.

The Director of Care (DOC) confirmed that the expectation of staff is to add requested/preference items to the care plan and it was not.

Sources:
A resident's clinical records and interviews with a PSW and the DOC.

[740915]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (c)

The licensee has failed to ensure that the interdisciplinary infection prevention and control team met at least quarterly and on a more frequent basis during an infectious disease outbreak in the home.

Rationale and Summary:
The home experienced multiple outbreaks between July 2022 and April 2023, with multiple residents and staff affected.

This Inspector was unable to locate IPAC meeting minutes with the exception of a meeting held on March 14, 2023.

Former IPAC Lead acknowledged that they had not had any other IPAC team meetings with the exception of the March 14, 2023, meeting.

Sources:
Search for IPAC team meeting minutes, review of CIS reports and interview with former IPAC Lead.

[670]

WRITTEN NOTIFICATION: Falls Prevention Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

The licensee failed to ensure that all direct care staff received annual training on the Falls Prevention and Management Program.

Rationale and Summary:
The GM of the home attempted to run the education report. Due to some technical difficulties, they were not able to obtain a complete staff list during the inspection time. However, the GM acknowledged from the small list obtained there were staff that had not completed the 2022, Falls education.

Sources:
Interview with GM and education records.

[725]

COMPLIANCE ORDER CO #001 Plan of Care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must:
-Conduct daily audits of the resident on varying shifts related to the resident's falls prevention interventions in place at the time of the audit.
-Document the date and time of the audit, the person completing the audit, the falls prevention interventions that should be in place, the falls prevention interventions that were in place at the time of the audit, if the electronic equipment was turned on and functioning, any discrepancies noted and actions taken to correct.
-Retain the audit documentation onsite and readily available.
-The General Manager will review the audits weekly and sign.
-Audits are to be completed for 90 days or until compliance is achieved.

Grounds
The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
A resident was observed attempting to get up and stand from their bed. The fall prevention intervention equipment was observed to be placed in an area that differed from the resident’s plan of care and the equipment was not turned on.

The resident's plan of care stated that the resident was to utilize the equipment when in bed and the equipment was to be placed in a specific area.

The DOC was notified and confirmed that the residents equipment was not turned on and not placed in the specified area per the plan of care.

Sources:
Observation, the resident's care plan and interview with the DOC.

670]

This order must be complied with by June 24, 2023

COMPLIANCE ORDER CO #002 Infection Prevention and Control

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (10)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must:
-The IPAC Lead or Director of Care or an Assistant Director of Care will analyze and monitor any infections in the home on a daily and monthly basis to identify any trends.
-Document all analysis, trends, corrective actions taken, date and the name of the person conducting the analysis. Keep this documentation onsite and readily accessible.
-The General Manager will review and sign the documentation at a minimum of weekly.

Grounds
The licensee has failed to ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Rationale and Summary:
The home experienced multiple outbreaks between July 2022 and April 2023, with multiple residents and staff affected.

A meeting was held on May 5, 2023, between the home and the Windsor-Essex County Health Unit

(WECHU). The minutes showed that WECHU had recommended the home conduct a gap analysis, root cause analysis to identify potential causative factors of transmission and complete a retrospective review of past outbreaks.

During an interview with the former IPAC Lead they acknowledged that they had been the IPAC Lead until mid April 2023, and that there was no formal process for tracking and analyzing infections in the home.

Sources:
Search for analysis and trending, CIS report review, meeting minutes and interview with former IPAC Lead.

[670]

This order must be complied with by August 11, 2023.

COMPLIANCE ORDER CO #003 Infection Prevention and Control

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must:
-IPAC Lead or the Director of Care or an Assistant Director of Care is to conduct daily tours of the resident areas in the home, on random shifts, to audit Personal Protective Equipment (PPE) use, hand hygiene, PPE caddy supply in rooms requiring additional precautions and signage in rooms requiring additional precautions.
-Complete documentation of the tours/audits that include the date, time, person completing the audit, observations, any discrepancies and corrective actions taken. Keep this documentation onsite and readily accessible.
-Audits are to be completed for 90 days or until compliance is achieved.
-Develop a process in the home to designate specific persons responsible for ensuring PPE supply in rooms requiring additional precautions are stocked twice daily
-The General Manager will review and sign all audits at a minimum of weekly.

Grounds
The licensee has failed to ensure that all staff participate in the implementation of the program,

including all members of the leadership team.

Rationale and Summary:

The Ministry of Long-Term Care received a complaint related to a staff member attending the home after testing positive for COVID. GM confirmed that when they became aware of the complaint they had investigated and the staff member did attend the home three days after testing positive for COVID, was not scheduled and should not have been at the home.

During the initial and subsequent tours of the home it was observed that resident rooms were missing required signage, there was an inadequate supply of PPE in resident rooms were additional precautions were required, staff were not wearing PPE as required or performing hand hygiene as required.

The GM stated that it was the expectation of the home that staff be masked at all times in the home when on duty and staff should utilize the required PPE for any resident requiring additional precautions.

Sources:

Observations, complaint review and interview with the GM.

[670]

This order must be complied with by July 11, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Compliance orders issued for the same legislation under O. Reg. 79/10 s. 229 (4) within inspection #2020_563670_0036 served February 3, 2021, and 2021_797740_0027 served November 24, 2021.

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #004 Administration of Drugs

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O. Reg. 246/22, s. 140 (2)

Specifically the licensee must:
-Ensure that drugs are administered to two specific residents in accordance with the directions for use specified by the prescriber.
-Complete a weekly audit and maintain a record of the audit outcome and action plan for the next two months for a variety of residents residing on different units related to transcribing physician orders to ensure the home's policies for obtaining and processing physician orders is followed.
-Complete a weekly audit and maintain a record of the audit outcome and action plan for the next two months related to the administration of medications by different Registered staff, to a variety of residents residing on different units.
-Provide training to all Registered staff on the home's policies for transcribing physician orders, medication administration; specifically related to medication rights and resident identifiers, according to Best Medication Practices to ensure residents are administered medications as prescribed.
-Maintain a record of the training, what the training entailed, who completed the training and when the training was completed. Keep this record onsite and accessible.

Grounds

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
A) A registered staff received a telephone order from a physician. The registered staff did not follow the home's policy and wrote the order down incorrectly. Subsequently, a resident received an incorrect dose of a medication until the error was discovered.

During an interview staff and the GM they indicated that the home's policies were not followed, that this was a serious medication incident where staff did not ensure medication administered to the resident was in accordance with the directions for use by the prescriber.

Sources:
Critical Incident System report, interviews, observations, record reviews including the home's investigative notes, and coroner's report.

Rationale and Summary:
B) A Critical Incident (CIS) System report was received by the Director, concerning a medication incident.

A registered staff, in error administered a medication to a resident that was not prescribed for them. The registered staff recognized their error and reported it immediately however had also failed to administer the medication to the resident for whom it was prescribed for.

During an interview an Assistant Director of Care (ADOC) indicated that they had responded to the incident and verified that the registered staff had not followed the home's policy to identify the correct resident, when they administered the medication to the wrong resident. The ADOC also confirmed that the Registered staff had not given the medication to the resident that it had been order for.

Sources:
CIS report, medication incident reports and investigative notes, the home's policies, resident's clinical records, observations and interviews with staff and a resident.

[115]

This order must be complied with by August 19, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Compliance orders issued for the same legislation under O. Reg. 79/10 s. 131 (2) within inspection #2020_563670_0036 served February 3, 2021, and 2021_797740_0028 served November 24, 2021.

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.